

CMA's Proposal for a Voluntary, Universally Available Health Benefits Program

A Socio-Economic Report of the Bureau of Research and Planning,
California Medical Association

● *The May 4, 1970 issue of the American Medical News contains an article on a report released in April by the British Medical Association following a two-year study of the British National Health Service. Although the BMA study is oriented to the specific program as it has evolved in Great Britain since 1946, its main thrust is in the development of a system of voluntary health insurance which would provide for greater consumer choice, based upon nationally determined guidelines and regulations. BMA's recommendations would have the NHS utilize a combination of tax-supported and voluntary-supported mechanisms in providing medical services to various segments of the population, based upon categories of illness and income levels.*

Since the BMA proposal as reported in the AMA News parallels in some respects the one approved by the CMA House of Delegates and submitted to the AMA House of Delegates for its consideration, the reader will be interested in seeing the concept for a Voluntary Universally Available Health Benefits Program, independently developed by the California Medical Association. It is interesting to note that the CMA proposal attempts to avoid many of the problems with which the NHS has been identified, and at the same time would establish a single, coherent, integrated approach for development over the next decade, incorporating public programs into a unified system of medical care which utilizes the multiplicity of voluntary health insurance approaches and mechanisms.

ALL INDIVIDUALS AND FAMILIES, regardless of income, age, or employment status, would be eligible, subject to the conditions and criteria cited below, either for coverage of acceptable levels of benefits through the issuance of vouch-

ers, or for tax credits for the purchase of acceptable levels of benefits as defined below:

1. All individuals and families, regardless of income, would be entitled to additional medical expense tax credits based upon a graduated percentage of such additional expenses but in no

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case less than 50 per cent of such additional expenses.

2. The determination of those individuals and families eligible to receive vouchers for acceptable levels of health benefit coverage would be based on budgets of adequate, but moderate, living costs as estimated by the Bureau of Labor Statistics, Division of Living Conditions Studies, and up-dated on a bi-annual basis for all areas of the country.

3. Where health care benefits are financed in whole or in part by an employer, tax credits to the individual or family would be applicable to supplement coverage to designated acceptable levels of benefits. Such tax credits would constitute the difference between the costs of benefits previously purchased and the health care budget component established by the Bureau of Labor Statistics.

4. Acceptable levels are defined as "low" or "high" options which contain essential and adequate health care provisions but which may be limited in some respects. The attached guidelines reflect the optimal (high) and acceptable (low) options to be made available; benefit levels and content of coverage may exceed those indicated.

5. Each individual would have a choice of plan or program which qualifies as an acceptable level of coverage.

6. Each individual would have an option of selecting his plan of coverage on an annual basis.

7. In view of the experience of the Bureau of Retirement and Insurance of the United States Civil Service Commission in administering the Federal Employees' Health Benefits Program, the Commission would be the Federal agency responsible for administering the Voluntary Universally Available Health Benefits Program. It would:

a. serve as a repository for all Federal funds, *i.e.*, Social Security trust fund and general tax revenues,

b. with the assistance of a National Advisory Medical Council, establish criteria for the definition of acceptable levels of benefit coverage; and

c. establish rules and guidelines for the guidance of State Civil Service Commissions or other similar agencies which would administer the program on State and territorial levels.

8. The foregoing Voluntary Universally Avail-

able Health Benefits Program would make it the responsibility of the Federal government to finance benefit coverage for Medicaid recipients, for an acceptable level of such coverage, with the State assuming the responsibility for financing the costs of any necessary supplemental coverage. This program would eliminate the present Medicare program and absorb it within the provisions cited above. Wherever feasible, the program would also absorb all other Federal programs financing health care benefits for other specialized categories of the population.

9. Other components and requirements:

a. In order to be eligible to receive payment, all institutions providing services would have to be accredited.

b. All institutions providing services would have to provide evidence of active utilization review committees.

c. All plans or programs approved to finance or provide services would have to furnish evidence of peer review activities to evaluate (1) the appropriateness of care provided and (2) the reasonableness of the charges made by providers of services.

10. In order to stimulate demonstration and experimental programs in the organization and delivery of health care, including utilization of new types of manpower, the Federal agency would, upon recommendation of its Medical Advisory Committee, provide grants for such purposes. Approval of grant applications by State Comprehensive Health Planning agencies would be a prerequisite to funding consideration and approval by the Civil Service Commission.

Guidelines to Components of Adequate Health Care Coverage

Optimal Level

I. Professional Services

A. Medical

1. Outpatient Medical Benefits

(a) Physicians' services, including consultations, for the diagnosis or treatment of illness or injuries.

(b) Psychiatric care. (Minimal benefits would be for acute psychiatric care.)

(c) Professional services for all baby care from birth through the first year of life. This should include provision for "well baby care."

(d) Inoculation and immunization of infants and adults against communicable diseases on a periodic basis, as indicated by good immunological opinion.

(e) Physical examinations on a periodic basis. (Adult and child periodic health surveys should be available.)

(f) Diagnostic X-ray and laboratory.

(g) Radiation therapy.

(h) Physical therapy—performed by, or under the direct supervision of, a physician.

2. In-Hospital Medical Benefits

(a) X-ray and laboratory services. (Where employed, co-insurance should apply equally to in- and outpatient.)

(b) Radiation therapy.

(c) Consultation.

(d) Physicians' services for the treatment of illness or injuries during a period of necessary hospitalization.

(e) Acute psychiatric care.

B. Surgical (all surgical procedures intended to bring about the care of illness or the repair of injury, in or out of hospital).

1. Assistant surgeons, as required.

2. Physicians' services for pregnancy, including prenatal, obstetrical and post-partum care.

3. Complications of pregnancy, e.g., ectopic pregnancy, caesarean section, spontaneous abortion.

4. Medically indicated sterilization procedures.

C. Anesthesiology: Anesthesiologists, as required.

II. Hospital Benefits

A. Inpatient Hospital Benefits required for the treatment of illness or injuries in a licensed hospital as follows:

1. At least 75 percent of the cost of a hospital's established two-bed rate (includes board and nursing services) for 365 days.

2. Drugs supplied by and used in the hospital, as well as oxygen.

3. The costs of all other hospital services, excluding charges for personal items expressly provided for the pleasure of the patient (e.g., TV, telephone, etc.).

4. Hospital Extras.

(a) This item should not include any professional services.

(b) It should, however, include the use of the surgery or delivery room, recovery rooms, inten-

sive care units, coronary care units, rehabilitation care units, supplies, etc.

5. Hospital care for pregnancy or any of its complications.

6. Psychiatric care, including psychiatric day care.

B. Outpatient Hospital Benefits for services provided by a licensed hospital:

1. The cost of operating, cystoscopic and cast rooms and their supplies.

2. The cost of emergency room and supplies when needed for medical and surgical emergencies.

III. Extended Care Facilities

A. Following hospitalization, or where medically indicated.

B. The cost of all necessary professional services, excluding personal services (for patient enjoyment).

IV. Home Health and Outpatient

Rehabilitation Services

Home visits by medical ancillary personnel of a recognized home health agency to provide, under direction of the attending physician, nursing care, treatments, health teaching and rehabilitative instruction necessary with respect to the treatment of illness or injury.

V. Ambulance Services, as ordered by physician.

VI. Prosthetic Aids, based upon medical need, as determined or approved by the physician.

VII. Drugs, outpatient.

VIII. Dental Care.

Example of Contract Exclusion: Cosmetic Surgery; other than those procedures related to birth defects and burns and scars due to injuries and illness.

Acceptable Level

I. Professional Services

A. Medical

1. Outpatient Medical Benefits.

(a) Physicians' services, including consultations, for the diagnosis or treatment of illness or injuries.

(b) Acute psychiatric care.

(c) Diagnostic X-ray and laboratory.

(d) Radiation therapy.

2. In-Hospital Medical Benefits

(a) X-ray and laboratory services. (Where

employed, co-insurance should apply equally to in- and outpatient.)

(b) Consultation.

(c) Physicians' services for the treatment of illness or injuries during a period of necessary hospitalization.

(d) Acute psychiatric care.

(e) Radiation therapy.

B. Surgical: All surgical procedures intended to bring about the care of illness or the repair of injury, in or out of hospital.

1. Assistant Surgeons, as required.

2. Complications of pregnancy—for example, ectopic pregnancy, caesarean section, spontaneous abortion.

C. Anesthesiology: Anesthesiologists, as required.

II. Hospital Benefits

A. Inpatient Hospital Benefits required for the treatment of illness or injuries in a licensed hospital as follows:

1. At least 75 percent of the cost of a hospital's established two-bed rate (includes board and nursing services) for 90 days.

2. Drugs supplied by and used in the hospital, as well as oxygen.

3. The cost of all other hospital services, excluding charges for personal items expressly provided for the pleasure of the patient (TV, telephone, etc.).

4. Hospital Extras.

(a) This item should not include any professional services.

(b) It should include, however, the use of the surgery or recovery rooms, intensive care units, coronary care units, rehabilitation care units, supplies, etc.

5. Hospital care for complications of pregnancy.

6. Psychiatric care, including psychiatric day care.

B. Outpatient Hospital Benefits for services provided by a licensed hospital:

1. The cost of operating, cystoscopic and cast rooms and their supplies.

2. The cost of emergency room and supplies when needed for medical and surgical emergencies.

III. Prosthetic Aids

Prosthetic Aids: Based upon medical need, as determined or approved by the physician.

Example of Contract Exclusion: Cosmetic Surgery; other than those procedures related to birth defects and burns and scars due to injuries and illness.

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This proposal contains a number of elements which represent improvements over other proposals. Among these are the following:

- It is the only one in the "voluntary" group that includes coverage for both Medicare and Medicaid recipients.
- It promotes the concept of "mainstream" care.
- It represents a realistic approach based upon costs of living (and their adjustment) rather than keying tax credits to "adjusted gross income" or "tax liability" concepts.
- It would enable the unemployed and uninsurables to participate in the program.
- It would assign administrative responsibility to an agency of government which has had almost a decade of experience with the Federal Employees' Health Benefits Program which incorporates program content options and periodic choice of program or plan by enrollees.
- It need not interfere with union, management, or collective bargaining decisions.
- It specifies provisions for levels of coverage which promote accessibility to care, based upon professional judgment.
- It makes provision for an advisory medical committee which can play a significant role in the administration of the program, both nationally and on the state level.
- It affords each state with the opportunity to administer the program under national guidelines, and therefore adds to the flexibility of administration.
- It enables the medical profession to demonstrate its capabilities in peer review and utilization review activities.
- It provides for demonstration and experimental approaches with which the medical profession is concerned, and above all
- It tries to create some order out of the "patchwork quilt" of programs now in existence which finance health care services to the American public, thereby promoting and establishing a single, coherent, systematic and coordinated approach to the provision and financing of medical care.